MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** () Yes (x) No
Requestor's Name and Address Wol+Med; Dr. H, M.D. 2436 IH-35 E, South #336 Denton, TX 76205	MDR Tracking No.: M4-04-2386-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address Liberty Mutual Fire Insurance P.O. Box 168208 Irving, TX 75016 Box 28	Date of Injury: Employer's Name: Insurance Carrier's No.: 949358836

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		**CPT Code(s) or Description**	**Amount in Dispute**	**Amount Due**
From	**To**			
11/12/02	**11/12/02**	**E1399**	**$85.00**	**$85.00**

PART III: REQUESTOR'S POSITION SUMMARY

Position Summary dated 11/6/03 states in part, "For date of service 11/12/03, CPT E1399, the carrier failed to respond to our initial billing and to ur request for reconsideration. We feel they have failed to comply with Rule 133.304. Medical payments and Denials…"

PART IV: RESPONDENT'S POSITION SUMMARY

The Respondent did not submit a position summary.

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

- HCPCS Code E1399 for date of service 11/12/03. EOBs were not submitted by either party. Per Rule 133.307(e)(2)(B) the requestor has submitted convincing evidence (letter from USPS showing delivery date, time and person to whom delivered). Per the 1996 Medical Fee Guideline, DME Ground Rule (X)(C) TENs units supplies are reimbursed at $85.00. Reimbursement in the amount of $85.00 is recommended.

PART VI: DETAIL FINDINGS (If needed)

Date of Service	CPT Code	Amount in Dispute	Amount Due	Date of Service	CPT Code	Amount in Dispute	Amount Due
11/12/2002	E1399	$85.00	$85.00				
				Total Left Column:			$85.00
				Total Amount Due:			$85.00

PART VII: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to additional reimbursement in the amount of $85.00. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 20-days of receipt of this Order.

Ordered by:

Authorized Signature	Marguerite Foster Typed Name	01-31-05 Date of Order

PART VIII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____